COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

LOCAL GOVERNMENT PROVIDER FEES and LOCAL GOVERNMENT INPATIENT AND OUTPATIENT HOSPITAL PAYMENTS

MANUAL FOR LOCAL GOVERNMENTS AND HOSPITAL PROVIDERS

FISCAL YEAR 2008

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ARTICLE I. OVERVIEW

This manual describes the process whereby local governments in Colorado may impose on nongovernmental (private) hospitals within their jurisdiction fees which qualify for supplemental federal Medicaid funds. Total funds are then redistributed to participating hospitals in accordance with State and federal regulations. The Colorado Department of Health Care Policy and Financing (the Department) oversees this process.

In 2006, the General Assembly passed Senate Bill 06-145, "Concerning the Authority of a Local Government to Impose a Fee on Certain Medical Providers for Purposes of Obtaining Federal Financial Participation under Medicaid for Unreimbursed Medicaid Costs." Subject to federal law and regulations, this State statute on Medical Provider Fees authorizes local governments to assess a fee on the revenues of private hospitals within their jurisdiction. Local government participation is voluntary -- hospital provider participation within participating local governments is mandatory. The monies collected from the fee are supplemented with federal Medicaid funds, subject to the available Upper Payment Limit, and redistributed to private hospitals based on their unreimbursed Medicaid costs. In June of every year, the Department will make a lump-sum distribution to each participating local government based on the local government's share of available funds. Participating local governments are responsible for making the final Local Government Inpatient/Outpatient Hospital Payments to individual qualified hospitals within their jurisdiction from this lump-sum distribution based on the Department's distribution methodology.

In order to receive federal Medicaid funding for the Local Government Inpatient/Outpatient Hospital Payments, the Department was required to amend Colorado's agreement (State Plan) with the federal Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS). The Colorado Department of Health Care Policy and Financing has worked closely with CMS to devise an acceptable plan for implementing the Local Government Provider Fee process. While final approval is still pending, the Department believes that the procedures outlined in this manual are consistent with federal regulations. In instances where federal laws and regulations conflict with State statute, federal laws and regulations take precedence.

ARTICLE II. LOCAL GOVERNMENT ELIGIBILITY

Section 2.01 Eligible Governments

State statute, Section 29-28-102, C.R.S., limits local governments that may impose a fee on providers for purposes of obtaining federal financial participation. The following types of local governments may impose such a fee:

- Counties
- Home Rule Counties
- Home Rule Cities
- Statutory Cities
- Towns
- Territorial Charter Cities, or
- Cities and Counties (such as the City and County of Denver)

Other types of local governments, such as special districts or other taxing authorities, may not participate in this program.

Section 2.02 Responsibilities of Participating Local Governments

The local government must notify the Manager of the Safety Net Programs Section within the Department of Health Care Policy of its intent to impose the Local Government Provider Fee on private providers of inpatient and/or outpatient hospital services by August 1st of each State fiscal year. Participation by local governments in this program is voluntary. State statute allows local governments to not assess a fee in any given year. Moreover, the federal Centers for Medicare and Medicaid Services (CMS) requires the Department to update Colorado's State Plan for this payment every year. Thus, the Department must be notified annually of the local government's intent to participate.

The local government must document its authority to impose the fee within its territorial jurisdictional boundaries. To demonstrate its authority, the local government may submit items such as copies of by-laws, charters, and/or ordinances or resolutions promulgating the fee.

The local government must document for the Department all hospitals that provide inpatient and/or outpatient services and reside within its jurisdiction. The local government must indicate all hospitals, both public and private, that reside within its territorial boundaries and must provide maps and other binding legal documents that validate such information (State law prohibits the imposition of the Local Government Provider Fee on public hospitals). However, in situations where a public hospital that provides inpatient and outpatient services resides within the territorial boundaries of a participating local government, the Department must submit a waiver to CMS requesting that the public hospital be exempt from the fee).

Fees must be assessed as instructed in this manual and agreed to by contract between the State of Colorado, Department of Health Care Policy and Financing and the local government. To qualify for Medicaid federal financial participation, fees must be imposed and collected in the prescribed manner. Failure to do so jeopardizes the supplemental federal Medicaid funds.

The local government must inform the Department of its assessment rate. Based on current federal legislation, the rate cannot exceed 5.5% of a provider's net inpatient (outpatient) revenues minus Medicare and Medicaid revenues for inpatient (outpatient) services. (See Article V, Section 5.02 for further details.) The assessment base that the rate is applied to has been agreed upon by the Department and CMS.

The local government must provide documentation that demonstrates the fee has been assessed and collected by June 20th of each State fiscal year the local government participates in the Local Government Provider Fee.

The local government must distribute the Local Government Inpatient and/or Outpatient Hospital Payment(s) in its (their) entirety to all participating hospitals within its jurisdictional territorial boundaries as instructed in this manual and agreed to by contract between the State of Colorado, Department of Health Care Policy and Financing and the local government. In June of every

year, the Department will make a lump-sum distribution of federal funds to each participating local government based on the local government's share of available State funds. Participating local governments are responsible for making the final Local Government Inpatient/Outpatient Hospital Payments to individual qualified hospitals within their jurisdiction from this lump-sum distribution. To qualify for federal financial participation, the local government Inpatient and/or Outpatient Hospital Payment(s) must be distributed to participating hospitals in the prescribed manner. Failure to do so jeopardizes the supplemental federal Medicaid funds.

Within thirty days of this payment, the local government must provide documentation to the Department which demonstrates payments have been made to each hospital as instructed.

NO PORTION OF THE LOCAL GOVERNMENT INPATIENT AND/OR OUTPATIENT HOSPITAL PAYMENT(S) MAY BE RETAINED BY THE LOCAL GOVERNMENT TO COVER ADMINISTRATIVE COSTS OF PARTICIPATING IN THE PROCESS OR FOR ANY OTHER REASON. The purpose of the payment is to reimburse participating hospitals for uncompensated Medicaid costs. Supplemental federal Medicaid funding cannot be diverted for any other purpose.

ARTICLE III. HOSPITAL ELIGIBILITY

Section 3.01 Eligible Providers

To qualify for the Local Government Inpatient and/or Outpatient Hospital Payment, a hospital must meet the following requirements:

- Provide inpatient and/or outpatient hospital services under the Colorado Medicaid Program; and
- Reside within the territorial boundaries of a participating local government.

Local governments may choose to participate or not participate in the Local Government Provider Fee; however, private hospital provider residing within the territorial boundaries of a participating unit of local government must participate. State and Federal regulations require each and every private hospital within a participating unit of local government to pay the assessed fee.

Section 3.02 Responsibilities of Participating Providers

All private hospitals within the territorial boundaries of a participating local government must provide a copy of their most recently audited Medicare/Medicaid cost report (CMS 2552-96) to the Cost Report Accountant within the Safety Net Programs Section of the Department of Health Care Policy and Financing by September 1st of each State fiscal year. Staff of the Safety Net Programs Section will compute allowable Local Government Provider Fees and resulting Local Government Inpatient and/or Outpatient Hospital Payments based on submitted cost reports. In some cases, further financial documentation, such as grouping schedules, may be necessary. These must be provided to the Cost Report Accountant if and when requested.

Participating hospitals must pay their assessed Local Government Provider Fee in a timely manner as prescribed by the local government in which they reside. Failure to do so jeopardizes the supplemental federal Medicaid funds.

Hospitals must provide documentation to the Department, by July 30th of each year, which demonstrates their receipt of the Local Government Inpatient and/or Outpatient Hospital Payment from the local government in which they reside.

ARTICLE IV. RESPONSIBILITIES OF THE DEPARTMENT

The Department shall serve as the sole liaison between participating local governments, private hospitals and the federal Centers for Medicare and Medicaid Services (CMS). As the single state agency responsible for the Medicaid program, when applicable, the Department will work closely with CMS to seek any necessary waivers to exempt local governments or hospitals affected by the Local Government Provider Fee from federal regulations or CMS requirements. As agreed upon with CMS, the Department will also amend the State Plan which outlines and administers Colorado's Medicaid program in conformity with federal regulations when required to accommodate any change in participating local governments or providers.

The Department will compute and inform participating local governments and private hospitals of allowable fees that may be imposed for inpatient and/or outpatient hospital services within their jurisdictional territorial boundaries by December 1st of each State fiscal year. Calculations will be based on each hospital's most recently audited Medicare/Medicaid cost report (CMS 2552-96). Fees shall be calculated as permitted by agreement with CMS.

The Department will compute the Local Government Inpatient and/or Outpatient Hospital Payment to each qualified provider by December 15th of each State fiscal year. Calculations of this payment shall be based on unreimbursed Medicaid costs, as calculated from each hospital's most recently audited Medicare/Medicaid cost report (CMS 2552-96), and shall be computed in accordance with Attachment 4.19-A of Colorado's State Plan.

Note that federal financial participation for the Local Government Inpatient and/or Outpatient Hospital Payments is limited by the specific "Medicare Upper Payment Limit" for these services. In summary, the federal government will not reimburse health care providers beyond the amount that Medicare would pay for these services. The limit for inpatient hospital services differs from the limit for outpatient hospital services. The Department calculates new limits, within federal guidelines, each year. Various supplemental Medicaid payments from the Colorado Indigent Care Program to qualified providers must stay within the upper boundary of this limit each year. All supplemental Medicaid payments that include federal financial participation fall within a hierarchical payment system specified in Colorado's State Plan. The Local Government Inpatient and/or Outpatient Hospital Payment is the last payment listed on this tiered payment system. Thus, in some years, not all Local Government Provider Fees collected may be eligible for full financial participation.

In December, the Department will also notify all participating local governments and hospitals of the final payments to be distributed by June 30th of each State fiscal year. The Department will not disclose the amount of payments made to one unit of local government to another unit of local government. The Department will not disclose the dollar amount of payments made to an individual qualified hospital to any other hospital.

The Department will seek full allowable federal financial participation within the bounds of the "Upper Payment Limit" on all Local Government Provider Fees received from participating local governments and forward the full value of the Local Government Inpatient and/or Outpatient Hospital Payment(s) to participating local governments by June 30th of each State fiscal year. Based on State statute, the Department must make the payments to the affected local governments rather than directly to individual qualified hospital providers.

ARTICLE V. THE LOCAL GOVERNMENT PROVIDER FEE

Section 5.01 General Information

Federal laws and regulations allow health care-related taxes (a.k.a. provider fees) to be imposed upon certain classes of health care services. Inpatient hospital and outpatient hospital services are permissible classes of service. In general, health care-related taxes must:

- Be broad-based;
- Be uniform; and
- Avoid hold harmless arrangements.

Provider fees must be broad-based, meaning that all providers of inpatient and outpatient hospital services within the territorial boundary of the imposing local government must be assessed. Since Colorado's law does not allow public hospitals to be assessed, the Department must request of CMS that the broad-based requirement be waived in instances where a public hospital is located within the territorial boundaries of a local government that chooses to impose the fee. If CMS were not to grant a waiver for such a request, the fee could not be assessed on any provider residing within the territorial boundaries of that local government.

Provider fees must be uniform. This requires a local government to assess all providers, for a specific health care class of service, at the same rate. While this is true within the boundaries of an individual local government, it need not apply across boundaries of local governments. Note also that even within an individual unit of local government inpatient and outpatient may be assessed at different rates since they are separate classes of health care services. The chart below illustrates various examples.

UNIFORMITY EXAMPLES

SITUATION	PERMISSIBILITY
Local Government A's assessment rate is 5% for all providers of inpatient hospital services within its jurisdiction.	**Permissible**
Local Government A assesses some providers of inpatient hospital services at 3% and some at 4%.	**Not Permissible**
Local Government A assesses providers of inpatient hospital services at 2% and providers of outpatient hospital services 5%.	**Permissible**

Local Government A assesses providers of inpatient hospital services and outpatient hospital services at the same rate.	**Permissible**
Local Government A assesses its providers of inpatient and outpatient hospital services at 1%; Local Government B assesses both its providers of inpatient and outpatient hospital services at 4.2%.	**Permissible**

In general, to avoid "hold harmless" situations, there must be "winners and losers" when the Local Government Inpatient and/or Outpatient Hospital Payments are distributed to participating hospital providers. Fees cannot be directly correlated with final reimbursement payments. The fact that Provider A pays a larger fee than Provider B does not require Provider A to receive a larger reimbursement. To avoid the possibility of a correlation, Colorado's State law and State Plan with CMS assess a fee based on hospital *revenues*, with the final payment distributed to hospitals based on their unreimbursed Medicaid *costs*. Indirect guarantees are also prohibited. Hold harmless situations are never acceptable; CMS will not consider waivers related to hold harmless requirements.

Federal law also prescribes revenue limits for provider fees. From January 1, 2008 through September 30, 2011, the allowable amount that can be collected from a health care-related assessment is 5.5% of net patient services revenues for either inpatient or outpatient hospital services. Assessment rates set higher than this rate raise questions of indirect guarantees of hold harmless arrangements and would subject the tax to further statistical scrutiny. To avoid this situation, Colorado will not exceed the 5.5% threshold.

Section 5.02 Assessment Base and Rate

The Centers for Medicare and Medicaid Services (CMS) and the Department have agreed that the assessment base for the Local Government Provider Fees is net patient revenues less Medicare and Medicaid revenues from the most recently audited Medicare/Medicaid cost report, adjusted for inflation. The assessment rate cannot exceed 5.5%, though it may be less than 5.5%. (See Article V, Section 5.01 on uniform rates.)

Thus, the Local Government Provider Fee for Inpatient Hospital Services shall not exceed 5.5% of net patient revenues for inpatient hospital services less Medicare and Medicaid inpatient revenues from the health care provider's most recently audited Medicare/Medicaid cost report (CMS 2552-96). Said revenues shall be inflated forward to the corresponding State fiscal year using the Consumer Price Index – Urban Wage Earners, Medical Care Index – U.S. City Average.

Assessment Base (Relevant Inpatient Revenue)	
Relevant Inpatient Revenue = Gross Inpatient Revenue –Medicare Inpatient Revenue –Medicaid Inpatient Revenue	
Value	***Location in CMS 2552-96***
Gross Inpatient Revenue	Worksheet C, Part I, Column 6, Line 101
Medicare Inpatient Revenue	Worksheet D-4, Title XVIII, Column 2, Line 101
Medicaid Inpatient Revenue	Worksheet D-4, Title XIX, Column 2, Line 101 [1]

Similarly, the Local Government Provider Fee for Outpatient Hospital Services shall not exceed 5.5% of net patient revenues for outpatient hospital services less Medicare and Medicaid outpatient revenues from the health care provider's most recently audited Medicare/Medicaid cost report (CMS 2552-96). Said revenues shall be inflated forward to the corresponding State fiscal year using the Consumer Price Index – Urban Wage Earners, Medical Care Index – U.S. City Average.

Assessment Base (Relevant Outpatient Revenue)	
Relevant Outpatient Revenue = Gross Outpatient Revenue –Medicare Outpatient Revenue –Medicaid Outpatient Revenue	
Value	***Location in CMS 2552-96***
Gross Outpatient Revenue	Worksheet C, Part I, Column 7, Line 101
Medicare Outpatient Revenue + Medicaid Outpatient Revenue	Worksheet D, Part V, Column 5, Line 101

Section 5.03 How to Calculate the Fee

The table below provides a hypothetical example of how the Department would calculate the Local Government Provider Fee for inpatient hospital services.

Step	How to Calculate the Assessment Fee for a Hypothetical Hospital	Amount
1	Net Patient Revenues for Inpatient Hospital Services	$3,000,000
2	Less Medicare and Medicaid Inpatient Revenues	$1,000,000
3	Equals Uninflated Revenue Base (Step 1 minus Step 2)	$2,000,000
4	Assessment Base (Step 3 Adjusted for Inflation)[2] i.e., ($2,000,000 x 1.2351)	$2,470,200

[1] If Worksheet D-4 is unavailable for Title XIX, use the provider's grouping schedule to obtain Medicaid Inpatient Revenues.

5	Assessment Rate	5.5%
6	Hospital Assessment (Step 4 multiplied by Step 5)	$135,861

The Department will calculate the provider fees for all hospitals in the same manner.

ARTICLE VI. THE LOCAL GOVERNMENT PROVIDER PAYMENT

Section 6.01 General Information

The Local Government Inpatient/Outpatient Hospital Payment (which includes federal financial participation) to qualified hospitals located within a participating local government is based on unreimbursed Inpatient/Outpatient Hospital Medicaid Costs subject to the Upper Payment Limit (UPL). An individual hospital's payment is based on the ratio of the hospital's inflated Unreimbursed Inpatient/Outpatient Hospital Medicaid Costs relative to the total inflated Unreimbursed Inpatient/Outpatient Hospital Medicaid Costs of all participating hospitals located within the territorial boundary of its local government. The payment distribution available to the group of hospitals within a specific local government is relative to the total payment available to all participating local governments throughout the State, which is determined by available funds under the UPL. The methodology for distributing the payments is purposely designed to benefit those hospitals that serve a proportionately greater share of Medicaid clients.

The Department will compute the Local Government Inpatient and/or Outpatient Hospital Payment to each qualified provider by December 15th of each State fiscal year and report the calculated amounts to the respective hospitals and local governments. Because any individual hospital's final payment is dependent on factors pertaining to other hospitals, it is not possible for providers to calculate payments themselves.

Section 6.02 Definition of Unreimbursed Medicaid Costs

Unreimbursed Inpatient Hospital Medicaid Costs equal Computed Medicaid Costs minus Medicaid Reimbursements, where:

a. Computed Medicaid Costs equal the provider's cost-to-charge ratio multiplied by Medicaid charges; and

b. Computed Medicaid Costs and Medicaid charges shall include only inpatient hospital services costs and charges that are distinctly identifiable on the provider's most recently audited Medicare/Medicaid cost report (CMS 2552-96) provided to the State by September 1 of each State fiscal year.

The following table shows where these costs and charges are located on the audited Medicare/Medicaid cost report (CMS 2552-96).

[2] Assume that the hypothetical hospital's recently audited cost reported was for year 2001. According to the Consumer Price Index ("CPI"), the U.S. city average inflation for Medicare Care between years 2001 and 2006 (the most recent full year available at the time of this example) was 23.51%.

Reimbursement Base (Uncompensated Medicaid Inpatient Hospital Services)	
Unreimbursed Medicaid Inpatient Hospital Services = $\left(\frac{\text{Total Costs}}{\text{Total Charges}} \times \sum \text{Medicaid Inpatient Charges}\right) - \left(\frac{\text{Total Medicaid Inpatient Charges}}{\text{Total Patient Charges}} \times \text{Total Medicaid Payment}\right)$	
Value	***Location in CMS 2552-96***
Total Costs	Worksheet C, Part I, Column 5, Line 101
Total Charges	Worksheet C, Part I, Column 8, Line 101
Medicaid Inpatient Charges	Title XIX, Worksheet D-4, Column 2, Line 101
Total Inpatient Charges	Worksheet C, Part I, Column 6, Line 101
Total Outpatient Charges	Worksheet C, Part I, Column 7, Line 101
Total Patient Charges	Total Inpatient Charges plus Total Outpatient Charges
Total Medicaid Payments	Title XIX, Worksheet E-3, Part III, Column 1, Line 57

Unreimbursed <u>Outpatient</u> Hospital Medicaid Costs equal Computed Medicaid Costs minus Medicaid Reimbursements where:

a. Computed Medicaid Costs equal the provider's cost-to-charge ratio multiplied by Medicaid charges; and

b. Computed Medicaid Costs and Medicaid charges shall include only outpatient hospital services costs and charges that are distinctly identifiable on the provider's most recently audited Medicare/Medicaid cost report (CMS 2552-96) provided to the State by September 1 of each State fiscal year.

Reimbursement Base (Uncompensated Medicaid Outpatient Hospital Services)	
Unreimbursed Medicaid Outpatient Hospital Services = $\left(\frac{\text{Total Costs}}{\text{Total Charges}} \times \sum \text{Medicaid Outpatient Charges}\right) - \left(\frac{\text{Total Medicaid Outpatient Charges}}{\text{Total Patient Charges}} \times \text{Total Medicaid Payment}\right)$	
Value	***Location in CMS 2552-96***
Total Costs	Worksheet C, Part I, Column 5, Line 101
Total Charges	Worksheet C, Part I, Column 8, Line 101
Medicaid Outpatient Charges	Title XIX, Worksheet D-4, Column 5, Line 101
Total Inpatient Charges	Worksheet C, Part I, Column 6, Line 101
Total Outpatient Charges	Worksheet C, Part I, Column 7, Line 101
Total Patient Charges	Total Inpatient Charges plus Total Outpatient Charges
Total Medicaid Payments	Title XIX, Worksheet E-3, Part III, Column 1, Line 57

Section 6.03 Reimbursement Examples

Illustrated in Appendix A are two examples of reimbursements. The reimbursement formulas do not differ between inpatient and outpatient assessments. Therefore, the example may be used to demonstrate either reimbursement example.

APPENDIX A:
Assessment and Reimbursement Example

Inpatient Assessment					
Locality	**Provider Name**	**Assessment Base** (Inflated Inpatient Revenues)	**Locality's Assessment Rate**	**Provider's Assessment**	**Locality's Total Assessment Collected**
Locality A	Provider A1	$15,000,000	**5.50%**	$825,000	$1,925,000
	Provider A2	$20,000,000		$1,100,000	
Total Assessment Base:		***$35,000,000***	***Total Assessments:***	***$1,925,000***	
Locality B	Provider B1	$35,000,000	**4.50%**	$1,575,000	$4,275,000
	Provider B2	$10,000,000		$450,000	
	Provider B3	$50,000,000		$2,250,000	
Total Assessment Base:		***$95,000,000***	***Total Assessments:***	***$4,275,000***	

Inpatient Reimbursement					
Locality	**Provider Name**	**Reimbursement Base** (Inflated Uncompensated Inpatient Costs)	**Provider's Reimbursement Base as Percent of Locality's Total**	**Locality's Funds Available for Redistribution** (Assessment + Federal Participation)	**Provider's Reimbursement**
Locality A	Provider A1	$2,000,000	33.3%	$3,850,000	**$1,283,333**
	Provider A2	$4,000,000	66.7%		**$2,556,667**
Total Reimbursement Base:		***$6,000,000***	***Total Reimbursements:***		***$3,850,000***
Locality B	Provider B1	$2,500,000	23.8%	$8,550,000	**$2,031,714**
	Provider B2	$3,000,000	28.6%		**$2,442,857**
	Provider B3	$5,000,000	47.6%		**$4,071,429**
Total Reimbursement Base:		***$10,500,000***	***Total Reimbursements:***		***$8,550,000***

Note – the Outpatient Assessment and Outpatient Reimbursement follows the same formulas and methodology.

Note: the example assumes that the UPL limit is high enough to allow all localities to receive full federal financial participation on the fees collected. If less room existed under the UPL limit, fees collected by each locality would be met by federal dollars at less than a 1:1 ratio.

APPENDIX B:
Proposed State Rule: Local Government Inpatient Hospital Payment

8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

C. Distribution of Available Funds to Providers

17. Local Government Inpatient Hospital Payment. This payment is a supplemental Medicaid payment to qualified providers that have been assessed fees by the local government in which they reside.

a. Definitions:

(1) "Local Government" means a county, home rule county, home rule city, statutory city, town, territorial charter city, or city and county.

(2) "Qualified Provider" means a non-governmental (private) hospital that provides inpatient hospital services under the Colorado Medicaid Program and resides within the territorial boundary of a local government that imposes a local government provider fee.

(3) "Local Government Inpatient Hospital Provider Fee" (fee) means a local government assessment imposed on private providers of inpatient hospital services in accordance with Colorado Statute, and Colorado's State Plan with the federal Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS) and Section 8.903.C.17.d.

(4) "Local Government Inpatient Hospital Payment" (payment) means the payment, including federal financial participation, distributed to qualified providers of inpatient hospital services, in accordance with Colorado Statute, and Colorado's State Plan with the federal Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS) and Section 8.903 C. 17. e.

b. A participating local government:

(1) Must notify the Manager of the Safety Net Programs Section within the Department of Health Care Policy and Financing of its intent to impose the Local Government Provider Fee on private providers of inpatient hospital services by August 1st of the State fiscal year.

(2) Must document authority to impose the fee within its territorial jurisdictional boundaries.

(3) Must document all hospitals, both public and private, that reside within the jurisdiction.

(4) Must inform the Department of its assessment rate.

(5) Must provide documentation that demonstrates the fee has been assessed and collected by June 20th of each State fiscal year the local government participates in the payment.

(6) Must distribute the Local Government Inpatient Hospital Payment in its entirety to all participating hospitals within its jurisdictional territorial boundaries as instructed by the State.

(7) Must provide auditable documentation to the State, within thirty days of distributing the payments, demonstrating that payments have been made to each qualified provider as instructed.

(8) Must ensure that no portion of the Local Government Inpatient Hospital Payment will be retained by the local government for any reason nor will any portion of the payment be diverted for any other purpose other than distribution to qualified providers as instructed by the State.

c. A qualified provider:

(1) Must be a nongovernmental privately-owned hospital that provides inpatient hospital services under the Colorado Medicaid Program.

(2) Must reside within the territorial boundary of a participating local government.

(3) Shall provide the State with its most recently audited Medicare/Medicaid cost report (CMS 2552-96) by September 1 of each State fiscal year.

d. The Local Government Inpatient Hospital Provider Fee for Inpatient Hospital Services shall not exceed 5.5% of net patient revenues for inpatient hospital services less Medicare and Medicaid inpatient revenues from the health care provider's most recently audited Medicare/Medicaid cost report (CMS 2552-96). Said revenues shall be inflated forward to the

corresponding State fiscal year using the Consumer Price Index – Urban Wage Earners, Medical Care Index – U.S. City Average.

e. The Local Government Inpatient Hospital payment to qualified providers within the territorial boundary of a local government shall be based on Unreimbursed Inpatient Hospital Medicaid Costs such that:

(1) Unreimbursed Inpatient Hospital Medicaid Costs shall equal Computed Medicaid Costs minus Medicaid Reimbursements, where: Computed Medicaid Costs shall equal the provider's cost-to-charge ratio multiplied by Medicaid charges; and Computed Medicaid Costs and Medicaid charges shall include only inpatient hospital services costs and charges that are distinctly identifiable on the provider's most recently audited Medicare/Medicaid cost report (CMS 2552-96) provided to the State by September 1 of each State fiscal year.

(2) Unreimbursed Inpatient Hospital Medicaid Costs shall be inflated forward to the corresponding State fiscal year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average.

(3) A qualified provider's payment is based on the ratio of the provider's inflated Unreimbursed Inpatient Hospital Medicaid Costs relative to the total inflated Unreimbursed Inpatient Hospital Medicaid Costs of all providers that reside within the territorial boundary of a participating local government. The payment distribution available to providers within a local government is relative to the total payment available to all participating local governments.

f. The State:

(1) Shall serve as the sole liaison between a participating local government, qualifed providers within its jurisdiction and the federal Centers for Medicare and Medicaid Services (CMS) for all matters pertaining to the fee and payment.

(2) Shall compute and inform a local government and qualified providers of allowable fees that may be imposed on private hospital providers of inpatient hospital services within their jurisdictional territorial boundaries by December 1st of the State fiscal year.

(3) Shall compute the Local Government Inpatient Hospital Payment to each qualified provider by December 15th of the State fiscal year. Calculations of this payment shall be based on unreimbursed Medicaid costs, as calculated from each hospital's most recently audited Medicare/Medicaid cost report (CMS 2552-96). Computations must be in accordance with Attachment 4.19-A of Colorado's State Plan with the Centers for Medicare and Medicaid Services.

(4) Shall seek full allowable federal financial participation on all Local Government Provider Fees received from participating local governments and forward the federal financial participation to participating local governments by June 30th of each State fiscal year.

(5) Shall instruct local governments to distribute payments, fee and federal financial participation, as computed in Section 8.903 C.17.f.3.

8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

C. Distribution of Available Funds to Providers

18. Local Government Outpatient Hospital Payment. This payment is a supplemental Medicaid payment to qualified providers that have been assessed fees by the local government in which they reside.

a. Definitions:

(1) "Local Government" means a county, home rule county, home rule city, statutory city, town, territorial charter city, or city and county.

(2) "Qualified Provider" means a non-governmental (private) hospital that provides inpatient hospital services under the Colorado Medicaid Program and resides within the territorial boundary of a local government that imposes a local government provider fee.

(3) "Local Government Outpatient Hospital Provider Fee" (fee) means a local government assessment imposed on private providers of outpatient hospital services in accordance with Colorado Statute, and Colorado's State Plan with the federal Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS) and Section 8.903.C.18.d.

(4) "Local Government Outpatient Hospital Payment" (payment) means the payment, including federal financial participation, distributed to qualified providers of inpatient hospital services, in accordance with Colorado Statute, and Colorado's State Plan with the federal Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS) and Section 8.903C.18.e.

c. A participating local government:

(1) Must notify the Manager of the Safety Net Programs Section within the Department of Health Care Policy and Financing of its intent to impose the Local Government Provider Fee on private providers of outpatient hospital services by August 1st of the State fiscal year.

(2) Must document authority to impose the fee within its territorial jurisdictional boundaries.

(3) Must document all hospitals, both public and private, that reside within the jurisdiction.

(4) Must inform the Department of its assessment rate.

(5) Must provide documentation that demonstrates the fee has been assessed and collected by June 20th of each State fiscal year the local government participates in the payment.

(6) Must distribute the Local Government Outpatient Hospital Payment in its entirety to all participating hospitals within its jurisdictional territorial boundaries as instructed by the State.

(7) Must provide auditable documentation to the State, within thirty days of distributing the payments, demonstrating that payments have been made to each qualified provider as instructed.

(8) Must ensure that no portion of the Local Government Outpatient Hospital Payment will be retained by the local government for any reason nor will any portion of the payment be diverted for any other purpose other than distribution to qualified providers as instructed by the State.

c. A qualified provider:

(1) Must be a nongovernmental, privately-owned hospital that provides outpatient hospital services under the Colorado Medicaid Program.

(2) Must reside within the territorial boundary of a participating local government.

(3) Shall provide the State with its most recently audited Medicare/Medicaid cost report (CMS 2552-96) by September 1 of each State fiscal year.

d. The Local Government Outpatient Hospital Provider Fee for Inpatient Hospital Services shall not exceed 5.5% of net patient revenues for outpatient hospital services less Medicare and Medicaid outpatient revenues from the health care provider's most recently audited Medicare/Medicaid cost report (CMS 2552-96). Said revenues shall be inflated forward to the corresponding State fiscal year using the

Consumer Price Index – Urban Wage Earners, Medical Care Index – U.S. City Average.

e. The Local Government Outpatient Hospital payment to qualified providers within the territorial boundary of a local government shall be based on Unreimbursed Outpatient Hospital Medicaid Costs such that:

(1) Unreimbursed Outpatient Hospital Medicaid Costs shall equal Computed Medicaid Costs minus Medicaid Reimbursements, where: Computed Medicaid Costs shall equal the provider's cost-to-charge ratio multiplied by Medicaid charges; and Computed Medicaid Costs and Medicaid charges shall include only outpatient hospital services costs and charges that are distinctly identifiable on the provider's most recently audited Medicare/Medicaid cost report (CMS 2552-96) provided to the State by September 1 of each State fiscal year.

(2) Unreimbursed Outpatient Hospital Medicaid Costs shall be inflated forward to the corresponding State fiscal year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average.

(3) A qualified provider's payment is based on the ratio of the provider's inflated Unreimbursed Outpatient Hospital Medicaid Costs relative to the total inflated Unreimbursed Inpatient Hospital Medicaid Costs of all providers that reside within the territorial boundary of a participating local government. The payment distribution available to providers within a local government is relative to the total payment available to all participating local governments.

f. The State:

(1) Shall serve as the sole liaison between a participating local government, qualifed providers within its jurisdiction and the federal Centers for Medicare and Medicaid Services (CMS) for all matters pertaining to the fee and payment.

(2) Shall compute and inform a local government and qualified providers of allowable fees that may be imposed on private hospital providers of outpatient hospital services within their jurisdictional territorial boundaries by December 1st of the State fiscal year.

(3) Shall compute the Local Government Outpatient Hospital Payment to each qualified provider by December 15th of the State fiscal year. Calculations of this payment shall be based on unreimbursed Medicaid costs, as calculated from each hospital's most recently audited Medicare/Medicaid cost report (CMS 2552-96). Computations must be in accordance with Attachment 4.19-B of Colorado's State Plan with the Centers for Medicare and Medicaid Services.

(4) Shall seek full allowable federal financial participation on all Local Government Provider Fees received from participating local governments and forward the federal financial participation to participating local governments by June 30th of each State fiscal year.

(5) Shall instruct local governments to distribute payments, fee and federal financial participation, as computed in Section 8.903 C.18.f.3.